Kentucky Crime Victims Compensation Board
130 Brighton Park Blvd., Frankfort, KY 40601

HIV POST-EXPOSURE *FIRST* FOLLOW-UP EXAM / TREATMENT BILLING FORM

Patient Name: _____

Phone number: _____

To be entered by CVCB

CVCB case #_____

Attention authorized medical personnel administering treatment or service: check box for each service rendered.
Fax completed forms and <u>itemized bills</u> to (502) 573-4817.

For information, call the Crime Victims Compensation Board: (502) 573-2290 / (800) 469-2120.

First Follow-up Exam (Day 7-10):	**Patient Account #**	
Category	*Cost Reimbursement*	*Rendered*
Exam	$50	
Labs (Western Blot)	$50	

As the medical personnel authorized by KRS 216B.400 to perform sexual assault exams, I certify completion of the above checked categories.

_____

Printed Name Signature

_____

Facility (Payee) Address Phone # Federal ID #

Medication:	**Patient Account #**	
Category	*Cost Reimbursement*	*Rendered*
21-day meds	$600	

I certify completion of the above checked category.

_____

Printed Name Signature

_____

Facility (Payee) Address Phone # Federal ID #

KRS 346.200(9) No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist or health department , the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to KY Crime Victim Compensation Board for billing purposes.

_____ _____

Patient Signature Date